

*If you are a crime victim, you have certain rights under Massachusetts Law, and you are eligible for certain services.*

For further information about victim rights and victim services, contact the victim witness program in your local District Attorney's office or one of the statewide agencies listed below.

#### DISTRICT ATTORNEY VICTIM WITNESS PROGRAMS

Berkshire County	(413) 443-3500
Bristol County	(508) 997-0711
Cape and Islands	(508) 362-8103
Essex County	(978) 745-6610
Hampden County	(413) 747-1000
Middlesex County	(617) 679-6500
Norfolk County	(781) 830-4800
Northwestern District	(413) 586-5780
Plymouth County	(508) 894-6309
Suffolk County	(617) 619-4000
Worcester County	(508) 792-0214

#### STATEWIDE VICTIM ASSISTANCE PROGRAMS

Office of the Attorney General	(617) 727-2200
Massachusetts Office for Victim Assistance	(617) 727-5200
Massachusetts Parole Board	(617) 727-3271
Criminal History Systems Board	(617) 660-4690
United States Attorney's Office	(617) 748-3100
Department of Youth Services	(617) 960-3290
Department of Corrections	(866) 684-2846

This document is available in alternate formats.

# VICTIM COMPENSATION

Financial  
Assistance  
for Victims of  
Crime in the  
Commonwealth of  
Massachusetts

OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY  
VICTIM COMPENSATION  
AND ASSISTANCE DIVISION  
ONE ASHBURTON PLACE  
BOSTON, MA 02108  
(617) 727-2200  
TTY: (617) 727-4765  
[WWW.MASS.GOV/AGO](http://WWW.MASS.GOV/AGO)

## Dear Friend,

Violent crime impacts every aspect of a person's life. The resulting physical and psychological injuries can affect a person's ability to work, go to school, and meet their own individual goals and aspirations. Often victims may require treatment to address the injuries caused by the violent acts of another. The monetary expenses incurred--after losing a loved one, for medical and dental care, for psychological assistance, and by injuries resulting in an inability to work--should not serve to further victimize those who are affected by violent crime.

As Attorney General, I am committed to empowering crime victims and providing them with the tools and support they need to begin the healing process. Our Victim Compensation Division is one resource that works diligently to make this happen. We are able to provide financial assistance to eligible victims of violent crime for uninsured medical and dental care, mental health counseling, funeral and burial costs, and income lost due to the inability to work. Our division uses funds obtained from perpetrators, and can assist with expenses up to a maximum of \$25,000 per crime. My experienced staff will assist you in understanding your rights as a crime victim, determining what expenses may be eligible for compensation, and assessing what other resources are available to assist you.

If you or a loved one has been the victim of violent crime, please take some time to read this brochure and contact our Victim Compensation staff for further assistance.



Cordially,

Martha Coakley  
Massachusetts  
Attorney General

## Who is eligible?

- \* Victims of violent crime occurring in Massachusetts
- \* Dependents and family members of homicide victims
- \* Any person responsible for the funeral expenses of a homicide victim

## What are the requirements?

- \* The crime must have been reported to police within five days unless there is good cause for delay.
- \* You must cooperate with law enforcement officials in the investigation and prosecution of the crime unless there is a reasonable excuse not to cooperate.
- \* You must apply for compensation within three years of the crime. Victims under the age of 18 at the time of the crime may apply until age 21, or later in certain limited circumstances.

## What expenses are covered?

To the extent insurance or other funds do not cover your expenses, you may be reimbursed for:

- \* Medical and dental expenses (including equipment, supplies and medications)
- \* Counseling expenses (for victims, for family members of homicide victims, and for children who witness violence against a family member)
- \* Funeral/burial costs up to \$4,000
- \* Lost wages (for victims only)
- \* Loss of financial support (for dependents of homicide victims)
- \* Homemaker expenses
- \* **Expenses not covered:** property losses, compensation for pain and suffering, and all other losses

## How do I apply?

- \* Complete the application and return it to the Victim Compensation and Assistance Division for verification. In general, you will receive a decision 4 to 6 months later.
- \* Your claim can be reopened for future expenses.

# Application For Crime Victim Compensation

(Please print legibly and fill out both sides)

**For AGO use only:**

VC #

## I. Victim Information

Victim's name \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_  
 Mailing address \_\_\_\_\_ Home telephone ( ) \_\_\_\_\_  
 City/State \_\_\_\_\_ Zip \_\_\_\_\_ Work telephone ( ) \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Age at time of incident \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## II. Applicant Information

If victim is applicant, write "same;" if under 18, application must be completed by parent or guardian.

Applicant's name \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_  
 Mailing address \_\_\_\_\_ Home telephone ( ) \_\_\_\_\_  
 City/State \_\_\_\_\_ Zip \_\_\_\_\_ Work telephone ( ) \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Relationship to victim \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If filing on behalf of minor dependent(s) of homicide victim, relationship to minor dependent(s) \_\_\_\_\_

## III. Crime Information

Type of crime:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> armed robbery     | <input type="checkbox"/> arson          | <input type="checkbox"/> assault                | <input type="checkbox"/> child physical or sexual assault |
| <input type="checkbox"/> domestic violence | <input type="checkbox"/> drunk driving  | <input type="checkbox"/> other vehicular crimes | <input type="checkbox"/> homicide                         |
| <input type="checkbox"/> kidnapping        | <input type="checkbox"/> sexual assault | <input type="checkbox"/> stalking               | <input type="checkbox"/> other _____                      |

Exact location of crime \_\_\_\_\_ City/State \_\_\_\_\_

Date of crime \_\_\_\_\_ Date crime reported \_\_\_\_\_

(If NOT reported within 5 days, please explain why in attached statement.)

Name of police department \_\_\_\_\_ Investigating officer \_\_\_\_\_

Name(s) of person(s) who committed crime (if known) \_\_\_\_\_

If you have been assisted by a victim advocate in the court/district attorney's office, provide the name and telephone number of advocate \_\_\_\_\_

Briefly describe the crime and any injuries which resulted \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## IV. Expenses

Check types of expenses for which you seek compensation:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> medical services*          | <input type="checkbox"/> lost wages (for victim only)                                      | <input type="checkbox"/> counseling for victim*  |
| <input type="checkbox"/> medical supplies/pharmacy* | <input type="checkbox"/> loss of financial support (for dependents of homicide of victims) | <input type="checkbox"/> counseling for family members of homicide victim*                     |
| <input type="checkbox"/> dental services*           | <input type="checkbox"/> funeral/burial*   | <input type="checkbox"/> counseling for children who witness violence against a family member* |
| <input type="checkbox"/> homemaker expenses*        |  |  |

\*Attach copies of bills and/or receipts.

Name of funeral home \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

**V. Lost Income**

Complete if seeking lost wages or loss of support.

Victim's employer \_\_\_\_\_ Contact person \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

If victim has or will return to work, estimated period of disability \_\_\_\_\_

If requesting financial support for dependent(s) of a homicide victim, provide the following information:

Name(s) of dependent(s)	Date of birth	SSN	Relationship to victim
_____	_____	- -	_____
_____	_____	- -	_____
_____	_____	- -	_____
_____	_____	- -	_____

**VI. Other Sources of Financial Assistance**

Check all potential sources of full or partial payment of expenses:

- health insurance
- life/accident insurance
- automobile insurance
- other (please specify) \_\_\_\_\_
- hospital-based "free care"
- unemployment benefits
- disability benefits
- workers' compensation
- public benefits (welfare, Medicare, Medicaid, SSDI)
- restitution

Names of applicable insurance companies \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_ Policy No. \_\_\_\_\_

Have you filed or do you intend to file a civil lawsuit? Yes \_\_\_\_\_ No \_\_\_\_\_ Not Sure \_\_\_\_\_

If yes, Attorney's name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

**VII. Optional Information**

For statistical purposes only.

- Race/ethnicity of victim:
- White
  - Black
  - Hispanic
  - Native American
  - Asian/Pacific Islander
  - Other
  - I decline to answer this question

Who referred you to Victim Compensation? \_\_\_\_\_

**Acknowledgment and Information Release**

I understand that the Victim Compensation Fund is a fund of last resort. I agree to inform the Division of any funds I receive from any source for losses for which I have requested compensation, and agree to promptly reimburse the Commonwealth for any such funds awarded to me or on my behalf.

I give permission to any hospital, medical facility, doctor, mental health provider, insurance company, employer, person or agency, including state and federal agencies, to give information to the Victim Compensation and Assistance Division. I understand that the information will be used to determine my claim for victim compensation benefits. I do not authorize the use or release of this information to any person or entity for any other purpose whatsoever. A photocopy of this signed release is as valid as the original. This authorization shall expire upon final determination of all requirements under G.L. c. 258C and 940 CMR 14.00.

I certify, under the pains and penalties of perjury, that all information and supporting documentation contained in this application is true and accurate to the best of my knowledge and belief.

X \_\_\_\_\_ Date \_\_\_\_\_  
Applicant signature (parent or guardian if victim is a minor)

**Return completed application to: Office of Attorney General Martha Coakley, Victim Compensation & Assistance Division  
One Ashburton Place, 19th floor, Boston, MA 02108-1698  
Tel: (617) 727-2200 Fax: (617) 742-6262**